AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

EMPLOYEE
NAME:_____**Z#**_____
Please Print

DATE OF INJURY/ILLNESS:_____

I hereby authorize LANL Occupational Medicine and other health care physicians and/or institutions to discuss information on the above work related injury/illness with each other and with Workers' Compensation Office staff and its Third Party Administrator, Occupational Healthcare Management Services.

I understand that I have the right to ask for and receive a true copy of this Authorization signed by me and that a reproduced copy of the Authorization will be as valid as the original.

I further understand that by NOT signing this release, my Medical and Workers' Compensation Benefits will not be affected.

Worker's
Signature:_____**Date:**_____

Witness Signature:_____

THIS FORM CANNOT BE ACCEPTED WITHOUT A WITNESS SIGNATURE

Revised April, 2002